VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

January 4, 2012

Ms.. Charlene Bedor, Administrator Administrator
Redstone Villa
7 Forest Hill Drive
St Albans, VT 05478-1615

Provider #: 475055

Dear Ms.. Bedor:

Enclosed is a copy of your acceptable plans of correction for the Life Safety Code survey conducted on **October 25, 2011**. Please post this document in a prominent place in your facility.

We will follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. BUILDING 01 - BUILDING 01 B. WING _____	10/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDSTONE VILLA	7 FOREST HILL DRIVE ST ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code inspection was completed on 10/25/11 by the Department of Public Safety. The following are violations of the Life Safety Code requirements for Nursing Homes.	K 000		
K 015 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure adequate interior finish for 2 applicable resident rooms. Findings include: Per observation on 10/25/11, accompanied by Maintenance Staff, Rooms 5 and 15 have damaged walls. This reduces the interior finish rating of the rooms.	K 015	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? The damaged walls in room #6 and room #16 were repaired on 10/28/2011. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Residents were not harmed by this alleged deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Maintenance Director & Housekeeping Staff will be reeducated on routine repairs on walls and door surfaces by 12/12/2011. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? Random Audits by Administrator/Designee on wall and door surfaces. Results will be reviewed at Quarterly QA Meeting 5. Include dates when a corrective action will be completed. Administrator/Designee will be responsible for monitoring to assure compliance with POC and regulatory requirements by 12/12/2011. K015 POC accepted 12/20/11 JBenard RN/CDRN	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only	K 018	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? All fire doors were tested and adjusted as needed on 11/1/2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlene Bedier — TITLE: Administrator — (X6) DATE: 12/7/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RNC

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K 018	Continued From page 1 required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure fire doors are fully operable in one area of the facility. Findings include: Per observation on 10/25/11, accompanied by Maintenance Staff, the fire doors in the corridor near the kitchen did not close and latch.	K 018	2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this alleged deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Maintenance Director will be reeducated on routine maintenance checks of fire door closure and latching by 12/12/2011. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? Maintenance Director will test fire doors weekly and adjust as needed. Random audits by Administrator or designee will be conducted on proper fire door closure and latching. Results will be reviewed at quarterly QA meeting. 5. Include dates when a corrective action will be completed. Administrator/Designee will be responsible for monitoring to assure compliance with POC and regulatory requirements by 12/12/2011. K018 POC accepted 12/20/11 J Benard / RN ctaRN	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper	K 056	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Ceiling tile was reset by Maintenance Director on 10/26/2011. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this alleged deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Maintenance Director will be reeducted on ceiling tile maintenance by 12/12/2011.	

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K 056	Continued From page 2 switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure that the building is maintained to assure proper functioning of the sprinkler system in one area of the building. Findings include: Per observation on 10/25/11, accompanied by Maintenance Staff, a portion of the ceiling tile in the closet located across from the employee break room had dropped out, impacting the timely operation of the sprinkler head.	K 056	4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? Maintenance Director will check ceiling tiles during daily rounds of building to ensure all tiles are set properly. Results will be reviewed at quarterly QA meeting. 5. Include dates when a corrective action will be completed. Administrator/Designee will be responsible for monitoring to assure compliance with POC and regulatory requirements by 12/12/2011. K056 POC accepted 12/20/11 J Benard/RN CotaRN	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure compliance with other fire safety/life safety standards. Findings include: 1. Per observation on 10/25/11, accompanied by Maintenance Staff, the primary air for the stovetop burners on the kitchen stove are out of adjustment as evidenced by long yellow flames. 2. Per observation on 10/25/11, accompanied by Maintenance Staff, a piece of the corridor handrail located across the corridor from the Beauty Station was found broken and taped	K 130	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? The primary air on the stove was corrected by a gas repairman on 10/26/2011. The handrail was replaced on 10/25/2011. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? No residents were affected by the alleged deficient practice. Residents who use the handrails for motivation have the potential to be affected by the alleged deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? All dietary staff and Maintenance Director will be reeducated on proper stove burner functioning by 12/12/2011. Maintenance Director will be reeducated on handrail safety and repair by 12/12/2011.	

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K 130	Continued From page 3 together.	K 130	**4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** **Administrator/Designee will conduct daily audits of stove burner functioning. Results will be reviewed at quarterly QA meeting.** **Administrator/Designee will conduct random audits of handrails monthly. Results will be reviewed at quarterly QA meeting.** **5. Include dates when a corrective action will be completed.** Administrator/Designee will be responsible for monitoring to assure compliance with POC and regulatory requirements by 12/12/2011. K130 POC accepted 12/2011 JBenard / RNstaRN	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure electrical wiring is in accordance with NFPA 70, National Electrical Code 9.1.2 in 2 areas of the facility. Findings include: Per observation on 10/25/11, accompanied by Maintenance Staff, the water coolers located in the second floor foyer and near the first floor Nurses Station are plugged into outlets that are not GFCI (Ground Fault Circuit Interrupter) protected.	K147	**1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** **Outlets located near the water coolers were replaced with GFCI outlets on 10/27/2011.** **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** **No residents were affected by this alleged deficient practice.** **3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** **Maintenance Director will be reeducated on outlets near water supplies by 12/12/2011.** **4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** **Administrator/Designee will monitor outlets near water supplies for future projects.** **5. Include dates when a corrective action will be completed.** Administrator/Designee will be responsible for monitoring to assure compliance of POC and regulatory requirements by 12/12/11. K147 POC accepted 12/2011 JBenard / RNstaRN	

		Redstone Villa, (the "Provider") submits this plan of correction, (POC), in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party any civil or criminal action against the Provider or any employee, agent, officer, director or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings, that are relied upon to adversely influence or serve as a basis, in any way, for the selection and / or imposition of future remedies, or for any increase in future remedies, whether any such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the State of Vermont or any other entity. Any changes to Provider Policy or Procedure should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceedings on that basis.	